

Case Number:	CM14-0044046		
Date Assigned:	07/02/2014	Date of Injury:	08/27/2007
Decision Date:	08/25/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/11/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 46 year-old female who reported an injury on 08/27/2007. The mechanism of injury was noted as cumulative trauma. The injured worker's diagnoses included an episode of mental/clinical disorder, adjustment disorder NOS, insomnia related to axis I disorder and rule out cognitive disorder NOS. Previous treatments included biofeedback therapy and cognitive behavioral therapy (CBT). Diagnostic studies were not provided in the medical records submitted for review. Surgical history was not provided in the medical records submitted for review. It was noted within the clinical note dated 03/10/2014 that the injured worker reported feelings of sadness, fatigue, loss of self-esteem, a sense of hopelessness, and a loss of pleasure in participating in usual activities. The documentation further noted the injured worker reported social avoidance, a lack of motivation, and loss of interest in sex and sleep disturbances. Additionally, the injured worker reported appetite changes, feelings of emptiness, experiencing crying episodes, but denied suicidal ideation. The objective findings noted no deficits with the injured worker's ability to express her thoughts coherently and rationally, there was no interview data to suggest self destructive behavior or aggressive propensity and the injured worker was able to provide a narrative of her situation. The documentation noted the injured worker was able to do most activities of daily living (ADL). The documentation noted the injured worker's Beck Depression Inventory (BDI) was 25 and Beck Anxiety Inventory (BAI) was 21. Medications included Amlodipine, Diovan, and Simvastatin; the dosages and frequencies were not provided in the medical records submitted for review. The provider requested follow-up visits every 6 to 8 weeks for 6 months. The rationale for the requested treatment was not provided in the medical records submitted for review. The Request for Authorization form was not provided in the medical records submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

FOLLOW UP OFFICE VISITS EVERY 6-8 WEEKS FOR 6 MONTHS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Office Visits.

Decision rationale: The request for follow-up office visits every 6 to 8 weeks for 6 months is not medically necessary. The injured worker has a history of depression and anxiety and to have participated in biofeedback and cognitive behavioral therapy (CBT) sessions. The documentation submitted for review noted the injured worker's Beck Depression Inventory (BDI) was 25 and Beck Anxiety Inventory (BAI) was 21. The Official Disability Guidelines recommend office visits as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. The documentation provided noted the injured worker has returned to work and is able to perform most activities of daily living (ADL). The documentation provided noted the current medication; however, that regimen did not include medications that required close monitoring. The requested treatment plan did not specify the type of office visits requested (e.g., cognitive behavioral therapy sessions, biofeedback sessions, physical therapy sessions, etc.). The request for multiple re-evaluations would not be indicated as the need for each office visit is determined by the prior office visit. The provider did not provide a rationale for the requested treatment plan. As such, the request for follow-up visits every 6 to 8 weeks for 6 months is not medically necessary.